Mental Health

Definition: Mental health is the successful performance of mental function, resulting in productive activities, fulfilling relationships, and the ability to adapt to change and to cope with adversity. Poor mental health refers to alterations in thinking, mood, or behaviors associated with distress and/or impaired function.[1] For this report, we define poor mental health in adults as having self-reported poor mental health 14 days or more in the past month and in youth as having symptoms of depression for two or more weeks in the past year.

Summary

Mental health provides a foundation for positive relationships and success in school and work. In Washington State in 2006, 9% (±1%) of adults reported experiencing poor mental health, such as stress, depression, and/or problems with emotions, for 14 days or more in the past month. In 2006, 30% (±1%) of 10th and 12th graders surveyed reported symptoms of depression in the past year.

The public health role in mental health is just emerging. This role can include surveillance of mental disorders and symptoms, identification of risk and protective factors, and population-level services such as providing information for early detection and intervention.

Most mental health interventions target individuals or families. Evidence-based treatment can achieve a 22% reduction in the risk for serious mental illness, but few studies have evaluated long-term effectiveness over periods of more than a year. Depression, the most common mental disorder, can be treated effectively with cognitive behavioral therapy or medications. People are less likely to experience further depression after stopping behavioral therapy than medications.

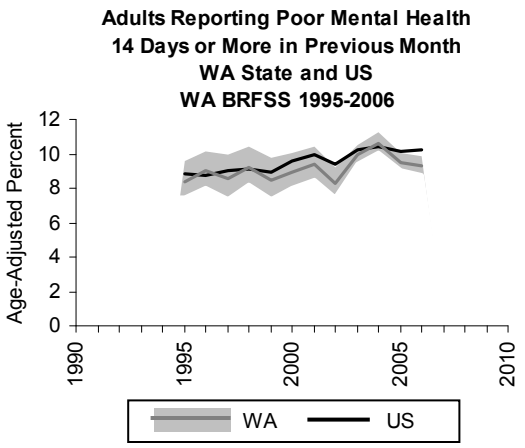
Introduction

Mental health and mental illness form a continuum of mental function that is vital to overall health and well-being. In 1999, *Mental Health: The Report of the Surgeon General* defined mental health as "a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and cope with adversity." The report summarized research indicating that mental health forms the foundation for learning, thinking, communicating, emotional growth, resilience, and self-esteem.[1]

Nearly all people experience some mental health problems or challenges at some point in their lives. Such challenges range from normal life stresses and worries to symptoms of mental disorders that affect but do not significantly impair daily function. In contrast, mental illness or mental health disorders are alterations in thinking, mood, or behaviors associated with distress and/or impaired function. Examples include depression, anxiety, psychosis, and cognitive problems.

Time Trends

In 2006 in Washington State, 9% (±<1%) of adults reported 14 or more days of poor mental health, including stress, depression, and/or problems with emotions, in the past 30 days on the Behavioral Risk Factor Surveillance System (BRFSS) survey. Rates of reported poor mental health did not change significantly between 1994 and 2006. In 2004–2006 combined, Washington rates of poor mental health were similar to the United States as a whole. Self-reported depression on the Healthy Youth Survey (HYS) by youth in grades 8, 10, and 12 did not change between 1999 and 2006.



Year 2010 Goals

The *Healthy People 2010* goals associated with mental health are related to acute care and treatment rather than prevention of mental health problems or development of supports and services to meet mental health needs of the population. Examples of the *Healthy People 2010* mental health goals are:

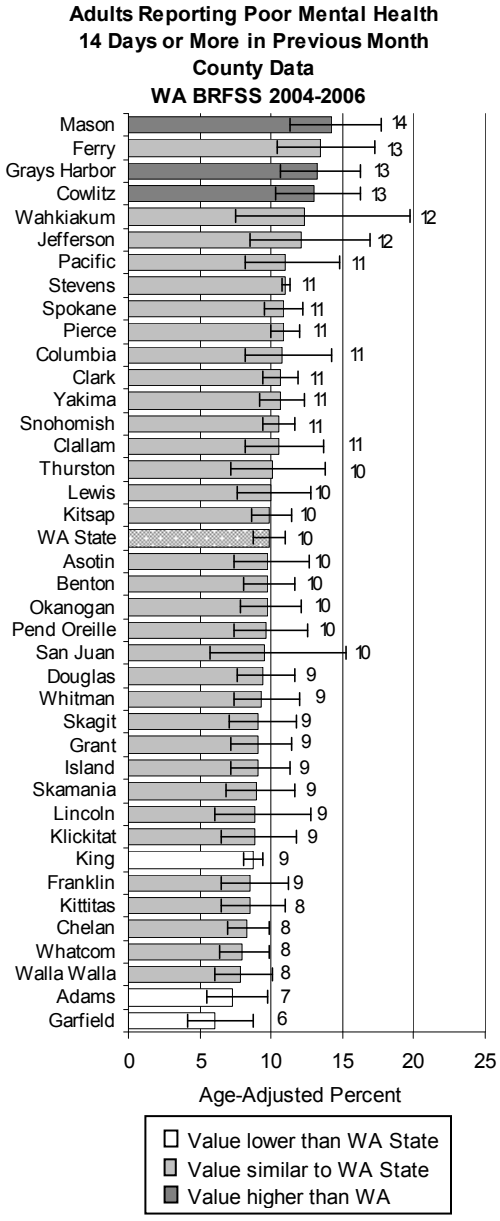
- Increase the proportion of homeless adults with mental health problems who receive mental health services to 30%.
- Increase the proportion of persons with serious mental illness who are employed to 54%.
- Reduce to 16% the proportion of adolescents in grades 9–12 who engage in disordered eating behaviors in an attempt to control their weight.

Data to assess progress toward the first two goals are not currently available. Washington 2004 HYS data suggest that Washington youth might have met the third goal. In 2004, 14% (±1%) of 8th-graders, 17% (±1%) of 10th-graders, and 16% (±1%) of 12th-graders reported engaging in disordered eating behaviors (such as using diet pills or vomiting) in the past month to lose or maintain their weight.

Future goals should address the need to promote social and emotional development in children, prevention of mental health problems, and supports and services for the general population.

Geographic Variation

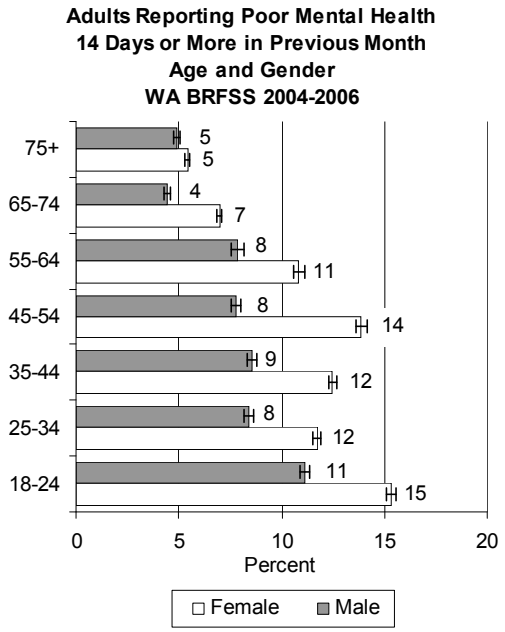
In 2004–2006, Mason, Grays Harbor, and Cowlitz counties had significantly higher percentages of adults reporting poor mental health compared to the state overall. King, Adams, and Garfield counties had lower percentages of adults reporting poor mental health. The percentages of adults reporting poor mental health levels varied from 14% in Mason County (the highest) to 6% in Garfield County (the lowest).



Age and Gender

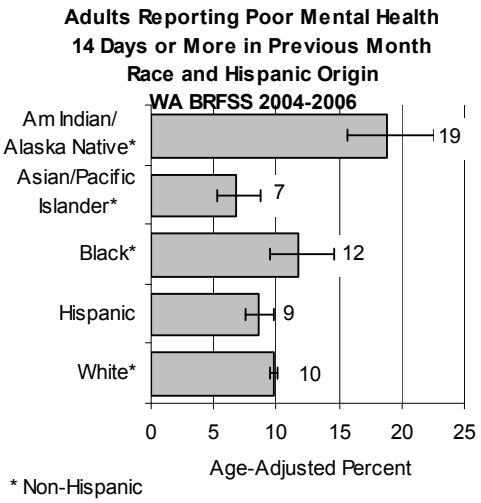
In 2004–2006, women and younger people reported poor mental health more often than men and older people. This is consistent with national 2006 BRFSS data and with research indicating women are more susceptible than men to depression.[2] Washington

women 18–24 years old reported the highest levels of poor mental health (15% ±2%). People 65 and older reported relatively low rates of poor mental health (6% ±<1%). These patterns, which are consistent with national 2006 BRFSS data, might be affected by willingness to report poor mental health, because suicide rates are elevated among the elderly.[3]



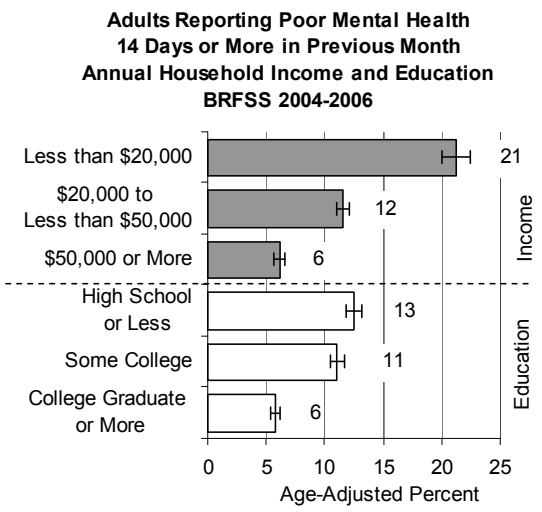
Race and Hispanic Origin

In 2004–2006, American Indians and Alaska Natives reported significantly higher rates of poor mental health (19% ±4%) than other racial and ethnic groups, including Asians and Pacific Islanders (7% ±2%), people of Hispanic origin (9% ±1%), blacks (12% ±3%), and whites (10% ±<1%). Blacks also reported more poor mental health than Asians and Pacific Islanders and people of Hispanic origin. These patterns persisted after adjusting for age, income, and education, except that the difference between blacks and Asians and Pacific Islanders was no longer significant.



Income and Education

Studies consistently show a negative association between socioeconomic status and mental illness. The lower an individual's socioeconomic status, the higher the risk of mental illness. The reasons for these associations are not well understood, but mental illness can limit success in education and employment. Washington BRFSS data show this association exists for reported poor mental health as well. While more than one out of five people living in households with annual incomes less than $20,000 per year reported poor mental health (21% ±1%), 12% (±1%) of those with household incomes between $20,000 and $50,000 per year and 6% (±1%) of those with incomes of more than $50,000 reported poor mental health.



The relationship of mental health and education is similar to that of mental health and income. Respondents with less education reported higher rates of poor mental health. These patterns persisted after adjusting for age.

Health Effects

Physical health. Mental and physical health are strongly related. Public mental health clients have higher rates of mortality and morbidity than the general population.[4,5] Recent general population surveys have also shown increased morbidity from a variety of physical conditions associated with depressive and anxiety disorders.[6] Whether poor mental health leads to poor physical health, poor physical health leads to poor mental health, or both are caused by a common risk factor is not clear.[7] In Washington from 2004–2006, 35% (±2%) of people who reported poor mental health in the past 30 days also reported 14 or more days of poor physical health compared to 8% (±3%) of other respondents. People reporting poor mental health also reported higher rates of smoking (56% vs. 41%), obesity (32% vs. 22%), and heavy drinking (29% vs. 23%).

Substance abuse. Alcohol and drug disorders frequently co-occur with other mental health disorders.[1,8] Individuals with substance abuse disorders and other mental health disorders are more likely to be chronically ill and to use services frequently than are those with either type of disorder alone.[1]

Suicide. People with mental health disorders have higher risks of suicidal ideation and suicide attempts, especially those with mood disorders, post-traumatic stress disorder, and possibly anxiety disorders.[1,9,10,11]

Barriers and Motivations

Stigma. Stigma associated with mental illness keeps some people from seeking treatment.[12] The same stigma can lead those who are not mentally ill to avoid and socially isolate those who are.

Access to care and preventive services. A recent needs assessment in Washington found that almost half of low-income people without health insurance were not able to access publicly funded mental health services. Those who were served by publicly funded services reported they couldn't always get care when needed because of limited services.[13] Preventive care is also limited. Nurse home visits in pregnancy and early childhood can reduce youth behavioral problems for as long as 15 years, but the program is not available to all high-risk families.[14] To address inequities between insurance coverage for mental health and general physical care, Washington has some of the strongest "mental health parity" laws for insurance coverage in the country, providing Washingtonians with relatively high levels of access to mental health care.[15]

Data gap. Population-based data systems are needed to monitor trends in mental health disorders and signs and symptoms as well as to evaluate prevention and health promotion efforts. Currently, we collect some data on adults, school-age children, and postpartum women, but more information on risk and protective factors, mental health services, and prevention efforts is needed. In addition, data are lacking on young children.

Other Measures of Impact and Burden

Mental illness. An estimated 20% of the U.S. population have a diagnosable mental disorder in a given year, including 5% who have a serious mental illness such as schizophrenia or bipolar disorder.[1] Depression, anxiety disorders such as phobias, obsessive-compulsive personality disorder, and post-traumatic stress disorder are relatively common mental disorders.[16,17]

Employment. Mental illness reduces peoples' ability to access and maintain employment. One study estimated that each year, five to six million people in the United States lose, fail to seek, or cannot find employment because of mental illness. The same study estimated that among employed individuals, mental illness decreased annual income by $3,500 to $6,000.[18] Mental illness can also lead to missed

days of work or decreased productivity, both among people with mental illness and their caregivers.

Criminal justice. Population-based mental health data are not available to compare rates of poor mental health among people in the criminal justice system and others. One U.S. Department of Justice report indicates this population has substantial mental health problems.[19] A recent Washington study reported that 16% of individuals receiving publicly funded mental health services in 2002 had at least one felony conviction in their lifetimes, compared with 7% of adults in the general population.[20] Data from the state Juvenile Rehabilitation Administration (JRA) show that 64% of the youth currently in JRA residential care have "significant mental health issues."[21] Some people with mental illness end up "recycling" in and out of the criminal justice system when appropriate mental health treatment is not available or accessible.[22] This cycle increases law and justice costs to communities. In many communities in the United States, jails and prisons become the largest providers of mental health services.[23]

Children and youth. Children and youth have similar rates of mental illness to adults. That is, about 20% have a diagnosable mental disorder in a given year. Based on data from the 2006 Washington HYS, about 25% of 8th-graders and 30% of 10th- and 12th-graders reported symptoms of depression in the past year. Girls were significantly more likely to report symptoms of depression than boys. From 12% to 15% of 8th-, 10th-, and 12th-graders reported they were very unlikely to seek help if they were feeling depressed or suicidal.

High Risk Populations

Family factors. Children who experience physical or sexual abuse or who witness domestic violence are more likely than others to have mental health problems as adults.[24] Children who have a mentally ill parent or other adverse childhood experiences such as parental substance abuse or criminality are also more likely to be depressed or have other mental health problems as adults.[25,26] In adulthood, being the victim of domestic violence is associated with increased rates of depression, anxiety, post-traumatic stress disorder, and other mental health problems.[27,28,29,30]

Genetic factors appear to play a role in some mental illnesses, such as schizophrenia, but the risks are poorly understood at this time.[31] Both genetic and social environmental factors might combine to increase the risk of mental illness.

Physical health and disability. Health problems such as heart disease are associated with poor mental health, although the cause-and-effect relationships are not well understood. People with disabilities involving activity limitations or requiring the use of special equipment such as wheelchairs are also more likely than others to report poor mental health.[32]

Stressful life events. Social events that involve a loss such as divorce or death of a spouse or family member are linked to mental distress and depression. Job stress (such as that created when high efforts reap low reward) is also linked to the development of common mental health problems such as depression.[33] Although most people experiencing a stressful or traumatic event recover without long-term consequences, some suffer long-term disturbances such as post-traumatic stress disorder.[34]

Race and ethnic origin. Although the Surgeon General's report did not find overall racial or ethnic differences in rates of mental illness, it noted that disproportionate numbers of African Americans were in groups at high risk for mental illness, such as the homeless or those in the correctional system. It also noted high suicide rates among American Indians and Alaska Natives, although mental health data are limited on these groups. Race and ethnic origin might also play a role in prevention and treatment. Language and cultural factors may limit access to some mental health providers. Some cultural and ethnic groups may be unwilling to seek help due to stigma and shame associated with mental illness in their cultures.[35]

Intervention Strategies

Public health role. The public health role in mental health is relatively new and still being developed. Historically, government has limited its focus to publicly funded mental health treatment and research. As the understanding of mental health and its role in overall well-being has grown, new roles have emerged for public health, notably:

1) Surveillance of mental disorders and mental health symptoms
2) Identification of risk and protective factors across the lifespan, and
3) Development of supports and services to address the mental health needs of the entire

population, such as providing information to parents, teachers, and caregivers about how to recognize the signs and symptoms of developing problems in children.

Mental health treatment. Most mental health interventions target individuals or families and use a range of psychosocial, medical, and self-help approaches. A common psychosocial approach, cognitive-behavioral therapy, attempts to change cognitions, such as unrealistic thoughts, or to teach behaviors, such as social or problem-solving skills.

Depression, the most common mental disorder, can be treated effectively with cognitive-behavioral therapy or medication, but it frequently recurs. Long-term improvements appear to be maintained better after cognitive-behavioral therapy than medication.[36,37] Cognitive-behavior therapy also reduces depression in children and adolescents. There is concern over whether some anti-depressant medications might increase suicidal behavior in youth.[38]

Evidence-based treatment can achieve a 22% reduction in the seriousness or incidence of severe mental illness, although few studies evaluated long-term effectiveness over periods of more than a year.[39]

Integration and access. Several national, state, and local initiatives have been implemented in recent years to increase integration of mental health services with other related services and to increase access to effective mental health services. One example is Systems of Care, an approach developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) to coordinate mental health services for children, youth, and their families. A Systems of Care network integrates the mental health treatment system with other systems serving children and families, including education, child welfare, juvenile justice, and other agencies. SAMHSA reports that emotional and behavioral problems were reduced significantly or remained stable for nearly 90% of children after 18 months in Systems of Care and that inpatient treatments and placements in juvenile detention were reduced.[40]

Another example of integration and access initiatives is supported by federal Mental Health Transformation State Incentive Grants. SAMHSA awarded these grants to seven states, including Washington, in 2005 and to two additional states in 2006. The primary goal of the grants is to create a more effective and efficient mental health system that provides high-quality, integrated services that are responsible to the specific needs of consumers and their family members. Consumer and family participation at policy, program, and treatment levels is a key component of both Systems of Care and Mental Health Transformation programs.

See Related Chapters: Alcohol Abuse and Dependence, Drug Abuse and Dependence, Suicide, Homicide, Child Abuse and Neglect, Youth Violence, Domestic Violence

Data Sources (For additional detail, see Appendix B).

State Behavioral Risk Factor Surveillance System (BRFSS): 1994–2005; 2003–2005 data weighted to reflect county over-sample, November 2006.

National BRFSS: U.S. Behavioral Risk Factor Surveillance System Data: 1994–2005, downloaded from http://www.cdc.gov/brfss/technical_infodata/surveydata.htm

Washington Healthy Youth Survey: Office of Superintendent of Public Instruction, Washington State Departments of Health, Social and Health Services, and Community, Trade, and Economic Development, and the Family Policy Council, 2002, 2004, 2006.

For More Information

A variety of information is available online from the National Institute of Mental Health at http://www.nimh.nih.gov/ (accessed January 11, 2008); the U.S. Centers for Disease Control and Prevention Mental Health Work Group at http://www.cdc.gov/mentalhealth/index.htm (accessed March 28, 2007); the U.S. Substance Abuse and Mental Health Services Administration at http://www.samhsa.gov (accessed January 11, 2008); the Washington State Department of Social and Health Services Mental Health Division at http://www1.dshs.wa.gov/mentalhealth/ (accessed January 11, 2008); and the Washington State Mental Health Transformation Project at http://mhtransformation.wa.gov (accessed January 11, 2008).

Technical Notes

A person is defined as having poor mental health when he or she answers 14 or more days in response to the BRFSS question, "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" This single question yields estimates of recent mental health similar to those based on longer questionnaires.[41]

Endnotes

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